PRIMARY HEALTH CARE NURSING INTEGRATION: BRIDGING THE GAP WITH CO-DESIGNED SHARED CARE

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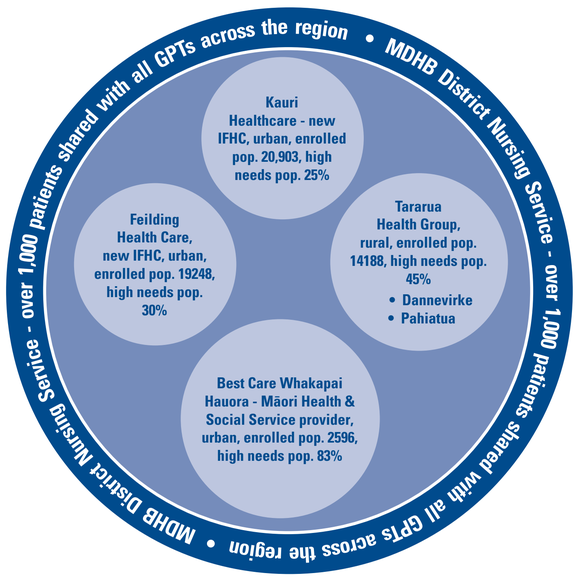
INTRODUCTION

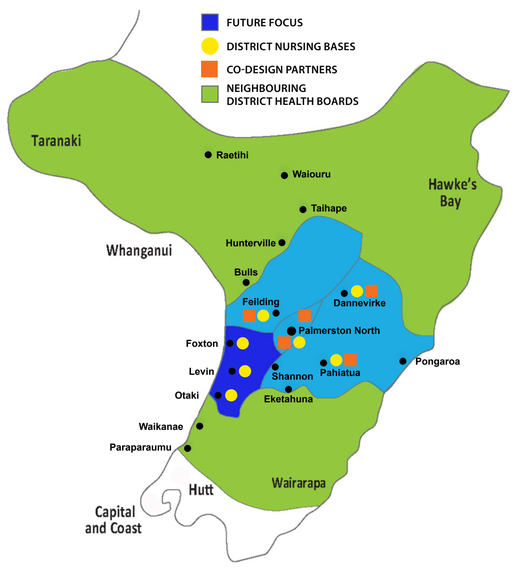
The Primary Health Care Nursing Integration project is a collaboration between the Central Primary Health Organisation (CPHO), the MidCentral District Health Board (MDHB) and primary health care services, all based in the lower North Island of New Zealand. The MDHB region covers a population of over 170,000, stretching from the West to East coasts. This population has a higher than average proportion of priority populations.

While the initial project focus related to the lack of alignment of the many Primary Health Care (PHC) nursing roles, the primary system dysfunction was the lack of integration between and across PHC and secondary services, resulting in disjointed patient care. Aims include best use of the total PHC nursing workforce, irrespective of employer, and nurses working to the top of their scope. The use of coproduction methodologies has broadened the project to encompass implementation of a co-designed model of shared care to bridge the gaps between services. This significant directional shift results in the scope extending past 'roles' and 'personnel' to care approaches and streamlined systems.

PROJECT APPROACH

- Via an expression of interest process, all General Practice Teams (GPTs) in the region were invited to become co-design partners with the MDHB District Nursing Service (DNS). Four GPTs (5 sites), with a representation of rural, urban, new Integrated Family Health Centres (IFHC), small and large practices, and Māori Health Providers are involved.





- Implementation was designed to be completed in 4 phases.

TIMELINE

January 2016	January 2017	January 2018	
Phase 1 Scoping & integration model co-design	Phase 2 Plan, pilot & evaluate implementation	Phase 3 Broaden implementation, care programmes, sites	Phase 4 Sustainable business as usual

PHASE ONE

- The overall focus was improving patient care - bridging the gaps in patients' journeys – and equity of service access and outcomes. No preset model was chosen. However, based on a literature review, we adopted a theoretical perspective that integration occurs along a continuum from segregation to full integration. There is no single degree of integration that is optimum for all services or care programmes.

Phase One Methodology

Methodology - scoping & co-design

- Interviews
- Data & document analysis
- Focus groups
- Mapping patient journeys
- Observations
- Considering national & international lessons

Change Processes and Priorities

- ✓ Relationships – face to face meetings, patient care discussion opportunities
- ✓ Understanding other services (& how they work, what they do, what they need)
- ✓ Streamlining processes & workflows
- ✓ Using other tools, such as clinical pathways
- ✓ Linking with other projects for consistent messaging, reducing service burden
- ✓ Testing, evaluating, testing, evaluating
- ✓ ICT – sub-project
- ✓ Different degrees of alignment depending on service configurations.

- Consumer engagement took place through in-depth interviews. With consent, patient journeys were mapped. These maps were utilised to initiate discussion at co-design workshops.

Patient Journey Map

Female, 70s, independent, lives alone. District Nursing involvement 4-5 times over the past 18 months for a. Post surgical wound dressing; b. Lower leg eczema. Has another chronic condition, self managed

WHAT WOULD MAKE A DIFFERENCE: If I could just go down to the clinic & ask the nurses to look at them. And if the doctor could listen – but because I haven't got a GP, they just sign things. I would certainly like to know the doctor I am going to, that I can go to every time. I have got another condition & nobody there knows about it. I'm not given my results. Everyone tells me something different. A shared plan would be useful.

- Does as much as she can to manage her condition – uses creams, wears stockings, elevates legs when possible
- Doesn't have a written ongoing plan
- Do the GPs know what the DNs are doing? – No; Do the DNs know what the GPs are doing? – No
- I don't have the same doctor, I have seen about 5 or 6 doctors & I just get to see whoever is around. No one has said 'what are you on all these tablets for?' They all have different ideas about what to do. There are all these different doctor's names on the letters & prescriptions & I don't know who the person signing the prescription is. There is no continuity of care. I don't know who my GP is.

KEY PATIENT MILESTONES	An active life, including caring for a family member for over a decade		DN clinic visits for leg dressings Referred for Doppler Advised to wear compression stockings		The Practice Nurse sent me to the District Nurses due to the cost. If I go down there [to the GPT] I have to keep paying. I think I paid $35.00. Even if they put a Band-Aid on I have to pay. The District Nurses only had to dress it from the ankle up [usually bandage from toes to knee]. My eczema was breaking out again but they wouldn't treat that as well – 'because that's not on the referral'. The District Nurses came home for a while because I couldn't weight bear.	The eczema gets really good, but it is always there		I'm not sick so that's why I go down to them [clinic], I am quite able to. There is probably someone out there that needs them to go to them more than I do. Set appointment times work – time doesn't bother me. Visit twice a week, usually a Tuesday & Thursday. I take the bandages off, have a shower & go down to the clinic & they put the dressings on	My feet hurt, especially when I'm walking. I can only walk about 10 minutes before my calves & feet get sore & I need to come home. There doesn't seem to be much I can do, I can't do the gardening any more – I have to pay someone, I like to get out & do things & it's stopping me. This one aches & this leg is painful. I feel there is nothing else they can do for them • I like looking nice & then I have to wear these stockings – the DN said 'don't be vain' – but I like to look after myself. I've got to wear these stockings all the time & with summer coming, my feet sweat • They discharge me & the moment they discharge me it all flares up again
		I've had eczema all my life. As I have got older it has got worse, on the bottom of my feet & legs – it makes me feel yuck, I'm over it. When it breaks down & is weeping I don't like people seeing them.		I saw another nurse for a Doppler & she suggested UV light for the eczema – I'm still waiting for the appointment. I used to go to the sun bed & my [previous] GP knew & my legs were good then.	Skin cancer taken off lower leg [under local] – they were going to do a skin graft but they didn't, they just sewed it up				
PHASES	Home	GPT→	Refer to District Nursing	District Nursing clinic	Hospital day surgery	GPT referral → District Nurses [home visits]	Home	GPT→	Referral to District Nursing	District Nurses [clinic]	Home
TIME						3-4 weeks					
	← OVER APPROXIMATELY 18 MONTHS →										

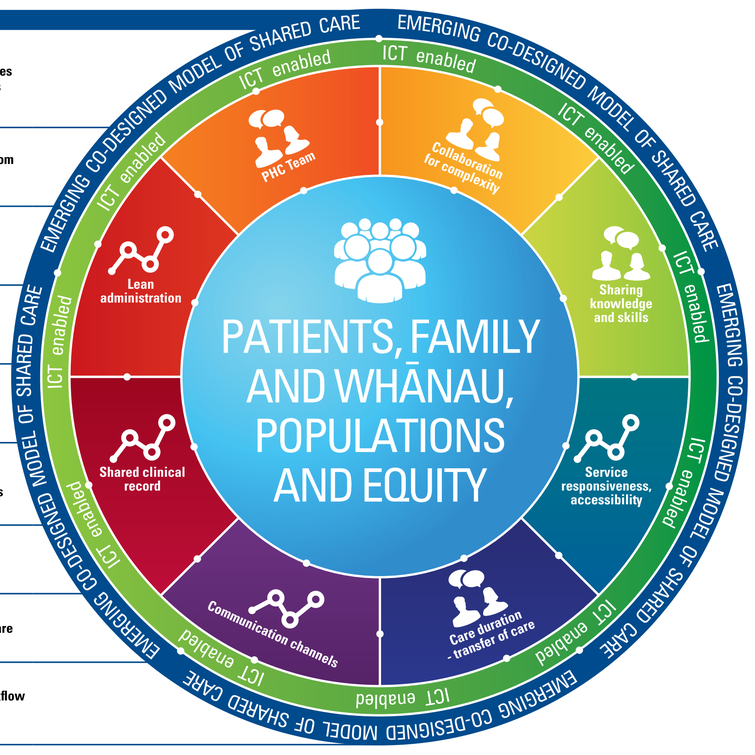
Key findings Phase 1

Patient focused care but:

- ✓ Busyness & heavy task workloads
- ✓ Silo-ed services – gaps, uneven patient transitions, unintended consequences
- ✓ Poor information transition
- ✓ Poor knowledge of other services, coordination across services
- ✓ Absence of ICT for District Nurses
- ✓ Complex needs, complex care
- ✓ Multiple projects underway
- ✓ Co-location ≠ integration

CO-DESIGNED MODEL OF SHARED CARE FOR PRIMARY HEALTH CARE NURSING INTEGRATION

CORE ELEMENTS	DESCRIPTION
Patient & population focus for a cohort of shared patients	Care within a broader team for those who would benefit. Those shared between services (and those who could benefit from the other's expertise, with or without a formal referral)
PHC Team	Aligned and virtual team of PHC clinicians from multiple roles
Care duration	Across long-term and episodic relationships with seamless transfer of care between PHC services
Knowledge & skills	Shared across an aligned and virtual team
Complexity and collaboration	Early identification and planning for complexity with multidisciplinary management
Service responsiveness, accessibility & equity	Appropriate point of care with shared clinic based care, more community care sites
Communication channels	Face to face, relationship based, electronic tools such as tasking via a General Practice Patient Management System + phone
Clinical records	Shared care, documented in one shared clinical record. Better sharing of pertinent care information
Administration & paperwork. Lean efficiencies	Co-designed processes that smooth the workflow and reduce clinicians' administration load

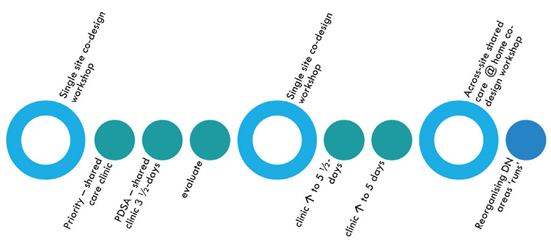


PHASE TWO

Local priorities were developed from each phase one workshop and testable solutions for Plan-Do-Study-Act (PDSA) cycles agreed. One PDSA example was to test the development of a 'shared care clinic' run by District Nurses within a new IFHC. Objectives were to:

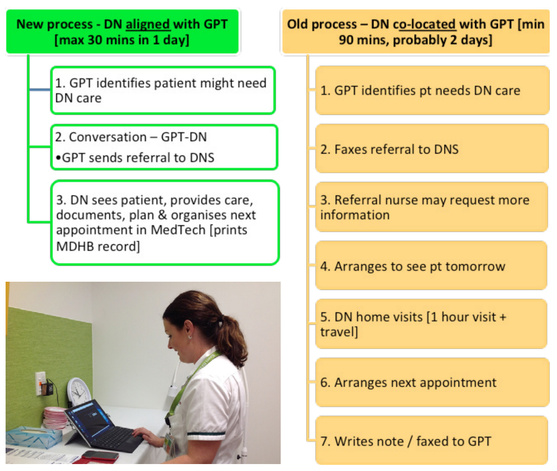
- Improve visibility of District Nurses as new members of the IFHC team
- Offer shared patients the option of receiving District Nursing care at their 'health home' (IFHC)
- Test processes of District Nurses documenting in-clinic care in the IFHC clinical records
- Improve shared understanding of patient care roles
- Improve understandings of shared patient care, especially for those with long term or complex care needs.

Case Study – test shared care clinic



- The clinic started three part days per week and has now increased to five days per week, with very positive outcomes for patients and staff (both the GPT and District Nursing).

Shared care clinic process changes



Shared care clinic outcomes – trust, team, teamwork

- ✓ Patient choice – opportunity costs
- ✓ Time released to care
- ✓ Earlier interventions
- ✓ Appropriate, timely referrals to other services
- ✓ Patients know team (& know the wider team knows!)
- ✓ Reduced requests for patient details
- ✓ Plan of care – in notes, identical plan given to patient
- ✓ Staff satisfaction
- ✓ Seamless transfers...

'The wider General Practice & District Nursing Teams worked together really well. They all had access to all the information they needed & the District Nurse had the backup of GPs as necessary'
[Patient interviewed as part of clinic evaluation]

'This has been of enormous benefit to Kauri Healthcare patients. I wish to thank [District Nurse] for all the advice and support she has given me. Thank you'
[KHC staff survey for clinic evaluation]

CO-DESIGNED MODEL OF SHARED CARE

- This co-designed model was a key outcome of Phases One and Two, and provides the basis for Phase Three.
- **TOOLKIT COMPONENTS**, necessary for the Shared Care Model to work effectively, have been tested in PDSA cycles on individual sites. However, due to delays in ICT implementation across the health sector, not all components have been tested on all sites
- All **ICT ENABLED** components have been tested in a limited way. MDHB progress on their Digital Strategy will ensure all can be tested in the future

TOOLKIT COMPONENTS	ICT ENABLED
• Identifying patients shared between services • Identifying clinicians involved in each patient's care. Flexible care coordination • Flexible coordination of care, especially for patients with complex needs • Shared care clinics for early referral, information sharing, seamless care transfer • Nurse-to-nurse regular meetings, including attending General Practice Team (GPT) huddles • PHC team involvement in MDT discussions, incl. specialist meetings such as Health of Older Person team • Increased use of clinics for those able to attend • Home-based care when appropriate • Streamlined transfer of care processes to provide advice at referral, earlier care at referral when appropriate • Increasing supported self management • Skills and knowledge shared for better patient outcomes, focusing on the right person with the right skills and knowledge providing care in the right place at the right time • Better understandings of patient complexity factors (research underway) • Early transfers of care in all directions • Local communication routines for the PHC team • Reduced care documentation processes for District Nurses • Link roles for smaller practices • Increased service level relationships	• Using the General Practice Team Patient Management system (GPT PMS) for shared clinical records • District Nursing Service (DNS) template for clinical records in the GPT PMS • Remote District Nurse (DN) access to the GPT PMS • Communicating electronically for non-urgent matters • Identifying other clinicians / roles involved in clinical records • A single patient focused plan of care (including for self management) • Transfer of care to the GPT on DNS discharge • Accessing the GPT patient summary via the MDHB portal • A lower limb wound prevention and management health pathway • Supported self-management plan discharge summaries for patients • Virtual consults • Clinical photos • Standardised referral templates for GPTs • Automatic acknowledgement of referrals received by the DNS • GPT alerts to DNs for events with shared patients, such as hospitalisations or deaths

Over phases one and two many lessons have been learned, which are being considered in Phase Three.

Lessons Learned

- ✓ Co-design takes time (& expertise)
- ✓ Link with like projects
- ✓ Use data (& evidence) for change & evaluation
- ✓ Blue sky thinking is hard
- ✓ ICT is an enabler, not the project
- ✓ There is much goodwill, but resourcing is important
- ✓ One bite at a time
- ✓ Working across services, including public and private, comes with its own challenges.

PHASE THREE UNDERWAY

Plan for Phase Three

- Increasing the number of General Practice sites, equity focus
- Implementing shared care @ home
- Reorganising the District Nursing workforce for complexity
- Scaling to the wider PHC nursing workforce
- Testing other degrees of alignment across the range of numbers of shared patients between services.

CONCLUSION

This project is work-in-progress. It demonstrates the positive impacts of following co-design principles to address widely experienced health sector integration challenges. The model of shared care that emerged from the first project phases, and which is being used to structure the third phase, has shifted the initial focus from roles and employers to care approaches and streamlined processes. ICT integration across organisations remains a key barrier to progress. However, effective service-level relationships have been developed, and patient and family focused solutions are informing all future developments.

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